STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155664	A. BUILDING _____ B. WING _____	C 04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00167285 and IN00169391. Complaint IN00167285 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00169391 - Unsubstantiated due to lack of evidence. Survey Dates: March 25, 26, 27, 30, 31 and April 1, 2015. Facility Number: 010666 Provider Number: 155664 AIM Number: 200229930 Census Bed Type: SNF/NF: 111 Total: 111 Census Payor Type: Medicare: 26 Medicaid: 51 Private: 8 Other: 26 Total: 111 Kindred Transitional Care and Rehab - Eagle Creek was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Recertification and State Licensure Survey and to the Investigation of Complaints IN00167285 and IN00169391.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE